

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

35526

State File No. \_\_\_\_\_

Registration District No. 4 1943 280Primary Registration District No. 4423Registrar's No. 25

## 1. PLACE OF DEATH:

- (a) County Platte  
(b) City or town Weston  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: none

(If not in hospital or institution, write street number or location)

- (d) Length of stay: In hospital or institution no (Specify whether

In this community entire life  
years, months or days)3. (a) PRINT FULL NAME Agnes O'Rourke Ode

3. (b) If veteran, name war XX 3. (c) Social Security No. XX

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married. 2 divorced, widowed  
6. (b) Name of husband or wife William C. Ode 6. (c) Age of husband or wife if alive XX years  
7. Birth date of deceased Sept 4 1884  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
59 1 5 hr. min.

9. Birthplace Platte City Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation housewife

11. Industry or business \_\_\_\_\_

12. Name Larence O'Rourke  
13. Birthplace XX Missouri  
(City, town, or county) (State or foreign country)  
14. Maiden name Mary Rich  
15. Birthplace Weston Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. George O'Rourke  
(b) Address Platte City, Missouri  
17. (a) Burial (b) Date thereof Oct 14-43  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Platte City, Missouri  
18. (a) Signature of funeral director W. R. Vaughn  
(b) Address Weston, Missouri  
19. (a) 10-19-43 (b) Mrs. Clay Syffe  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

- (a) State Missouri (b) County Platte  
(c) City or town Weston  
(If outside city or town limits, write "RURAL")  
(d) Street No. XX  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country XX

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct, day 9  
year 1943 hour 1 o'clock minute A.M.

21. I hereby certify that I attended the deceased from October 8 19 43 to October 9 19 43  
that I last saw him alive on October 8 19 43  
and that death occurred on the date and hour stated above.  
Immediate cause of death Chronic Myocarditis Duration \_\_\_\_\_

Due to HeartDue to ✓Other conditions Chronic inflammatory mastitis  
(Include pregnancy within 3 months of death)

- Major findings: Heart removed & analyzed  
breast removed 1942  
Of autopsy none made

PHYSICIAN

Underline the cause to which death should be charged statistically.

## 22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide (specify) ✓  
(b) Date of occurrence ✓  
(c) Where did injury occur? ✓  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
While at work? ✓ (Specify type of place) (e) Means of injury ✓

23. Signature Lewis C. Calverly (M. D. or other)  
Address Weston, Missouri Date signed Oct 14-43

1209

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Officer No. Platte  
District File Number 11-43-94  
Date Filed 11-2-43

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed

*W. R. Vaughan*

Licensed Embalmer No.

*4023*

P. O. Address

*Weston, Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. *202*

Registration District No. *280*

Primary Registration District No. *4423*

Registrar's No. *25*

1. PLACE OF DEATH:

(a) County *Platte*  
(b) City or town *Weston*  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution (Specify whether  
In this community years, months or days)

3. (a) PRINT FULL NAME

*Agnes O'Rourke Ode*  
3. (b) If veteran, name war. 3. (c) Social Security No.

4. Sex *F* 5. Color or race *W* 6. (a) Single, widowed, married, divorced *W*  
6. (b) Name of husband or wife 6. (c) Age of husband or wife If alive years min. (Day) (Year)  
7. Birth date of deceased *Sept 4 1904*  
(Month) (Day) (Year)

8. AGE: Years *59* Months *1* Days *10* If less than one day min.  
9. Birthplace (City, town, or county) (State or foreign country) *Mo.*

10. Usual occupation  
11. Industry or business  
12. Name  
13. Birthplace (City, town, or county) (State or foreign country)  
14. Maiden name  
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant (b) Address  
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)  
(c) Place: burial or cremation

18. (a) Signature of funeral director (b) Address  
19. (a) (Data received local registrar) (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County  
(c) City or town (If outside city or town limits, write "RURAL")  
(d) Street No. (If rural, give location)  
(e) Citizen of foreign country? (Yes or No)  
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *Oct* day *1* year *1943* hour *10* minute *30* M.  
21. I hereby certify that I attended the deceased from *Sept 4 1943* to *Oct 1 1943*, 19...;  
that I last saw him alive on *Sept 4 1943*, 19...;  
and that death occurred on the date and hour stated above.  
Immediate cause of death *Chronic myocarditis* Duration

Due to *Heart* 93d  
Due to  
Other conditions *Chronic inflammatory mastitis*  
(Include pregnancy within 3 months of death)  
Major findings: *not malignant*  
Of operations *Heart removed & sent for exam 1942*  
Of autopsy *no autopsy*

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify)  
(b) Date of occurrence  
(c) Where did injury occur? (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (c) Means of injury  
23. Signature *Lewis C. Calver* (M. D. or other)  
Address *Weston Mo.* Date signed *11/6/43*

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

35526